Naval Medical Center Portsmouth
Rheumatology Referral Guidelines

Diagnosis:	**Inflammatory Arthritis**

Clinic Name	Rheumatology
Clinic Phone Number	757-953-2160 or 2161
On Call Numbers	Duty Pager: 757-860-5702

1. Indications for Specialty Care:

- Patients found to have a chronic connective tissue disease such as systemic lupus erythematous (SLE) or Rheumatoid Arthritis (RA) should be referred to the Rheumatology Clinic for further evaluation. Many patients will be managed jointly by the primary care physician and Rheumatology specialist.

- Other patients who are not improving with symptomatic therapy should be referred, especially when the etiology of the condition is not clear.

2. Quality Consult Criteria

When referring a patient, please include as much of the following information as possible (OK to cut and paste this into consult request)

1. Provisional diagnosis
2. Duration of Problem
3. Prior treatments
4. Current treatments/medications
5. Diagnostic studies obtained (imaging, labs, other tests, etc.)
6. Primary reason for consult
7. Use of referral guidelines

3. Diagnosis Definitions

- Joint pain is a very common finding in the primary care clinic. Arthralgia is joint pain without evidence of inflammation.

- **Inflammatory arthritis is joint pain suggested by inflammation (swelling, warmth, erythema and tenderness).** When inflammatory arthritis is seen this should prompt the treating physician to initiate a thorough evaluation to identify the etiology. The inflammatory arthropathies encompass a very broad differential of diseases, including diffuse connective tissue diseases (CTDs), seronegative spondyloarthritis, crystal induced arthritis, metabolic conditions, and arthritis associated with infectious agents. Inflammatory arthritis symptoms generally are present for greater than 6 weeks.

4. Initial Diagnosis and Management

- **A thorough history and physical are the cornerstone to the evaluation of rheumatic complaints and should specifically address:**
    - Number and distribution of joints involved, small or large joints, symmetric or asymmetric, systemic symptoms, recent infections, trauma, medications, chronological history of symptoms, family history of CTDs and a complete review of systems looking for other associated conditions.

- A full general physical exam is essential with attention to the skin, scalp, nails and mucosal surfaces. The presence of subcutaneous nodules, rashes, telangiectasia, tophi, ulcers, psoriasis, emboli, vasculitic changes and onycholysis often suggest a rheumatic process. Pulmonary findings can accompany systemic lupus erythematosus (SLE), rheumatoid arthritis (RA) and systemic sclerosis.
    - A thorough physical exam includes: examination of all joints (not just the symptomatic ones) for signs of inflammation, assessment of range of motion, deformity, function, pain on motion (passive and active) and presence of effusion or synovial thickening. Pain due to inflammatory arthritis is generally localized to the joint space, or sometimes the periarticular structures.

- Lab evaluation is helpful, but rarely definitive in evaluating rheumatic complaints. **THERE IS NO SUCH THING AS A RHEUMATOLOGY PANEL.**
    - Acute phase reactants (ESR, CRP) are commonly elevated in inflammatory arthropathies and CTDs, but are neither sensitive nor specific and can be elevated in patients with any chronic disease (to include infections) as well as in patients who are obese. They can also be elevated due to age and weight. **They are not elevated only in rheumatic diseases.**
    - Specific immunological tests are best used to confirm a condition when there is clinical suspicion and should not be ordered when there is a low clinical suspicion for rheumatologic disease.
        - **RF, ANA and HLA B27 can be found in the normal population and when positive do not always represent disease.** There are also false positive results especially with an ANA screen and this lab should not be ordered with low clinical suspicion (i.e. a white male in his 50's).
        - ANA and extractable nuclear antigens are useful to further evaluate when there is suspicion for SLE, RF/CCP are helpful to further evaluate suspected RA.
    - Normal serum uric acid levels do not exclude gout nor do high levels confirm it. Many medications can contribute to elevated uric acid levels to include Lasix and Hydrochlorothiazide.
    - Routine testing of CBC, renal function, LFTs, and urinalysis can help evaluate for systemic disease as well as common viral etiologies such as HIV, HBV and HCV.

- Plain radiographs of the affected joint are rarely helpful in the early evaluation of inflammatory disease but can be helpful when symptoms have been ongoing for greater than 6 weeks.
    - It is helpful to image both sides of the body especially in RA – i.e. obtaining bilateral hand and foot X-rays along with evaluation of the chest for any extra-articular manifestations of the disease.

5. Ongoing Management and Objectives

- NSAIDs are the treatment of choice for inflammatory arthritis symptoms while the evaluation is in progress in patients without contraindications. Prednisone can also be used if severe inflammation without contraindications.
    - Many causes of arthritis are self-limited and frequently subside within weeks to 1 month with symptomatic therapy.
- In acute monoarthritis, infection or crystal induced disease are the likely causes and arthrocentesis is required to differentiate. If septic arthritis is the likely diagnosis then referral to orthopedics needs to occur.
- A symmetric small joint polyarthropathy in the metacarpal and proximal phalangeal joints as well as interphalangeal joints of the feet which is progressive, lasting for longer than 6 weeks and accompanied by prolonged morning stiffness, suggests RA. SLE looks just like RA when it affects the joints. SLE generally has other manifestations to include: malar rash, nasal and palatal oral ulcers, photosensitive rash.
- **Understanding age, gender and race helps differentiate amongst inflammatory arthritis especially between**

RA and SLE.
    - **Other inflammatory arthritis such as seronegative spondyloarthritis can present differently from RA and/or CTD's such as SLE.**
- Overall, patients with an inflammatory arthritis such as RA benefit from aggressive disease modifying therapy and should be referred early to a Rheumatologist if the diagnosis is strongly suspected.

6. Criteria for Return to Primary Care

- If the patient does have an inflammatory arthritis then the patient will be managed by Rheumatology.
- Not all joint complaints or symptoms are related to the underlying disease process. Even RA and SLE patients can get a common cold and this should be managed by the primary care physician.
- The primary care provider is expected to manage their other chronic conditions to include hypertension, hyperlipidemia and diabetes. The primary care provider should be a participant in the routine health maintenance such as cancer screenings and immunizations when appropriate.
- Any concerns or question should be handled as conversation between the referring provider/primary care physician and the consulting Rheumatologist.

Date Adopted or Last Reviewed:	01 Feb 2018	By	CDR Shauna O'Sullivan LCDR Jeffrey Eickhoff LCDR Terrence Kilfoil LCDR Jason Weiner
Referral Guidelines require review every three years.			

7. Resources/References

- American College of Rheumatology: https://www.rheumatology.org/
- Arthritis Foundation: https://www.arthritis.org/about-us/
- Lupus Foundation of America: http://www.lupus.org/